APPRAISAL/NEEDS AND SERVICES PLAN

CLIENT'S/RESIDENT'S NAME	DATE OF BIRTH	AGE	SEX ☐ MALE ☐ FEMALE
FACILITY NAME	ADDRESS		
PERSON(S) OR AGENCY(IES) REFERRING CLIENT/RESIDENT FOR PLACEMENT			FACILITY LICENSE NUMBER

Licensing regulations require that an appraisal of needs be completed for specific clients/residents to identify individual needs an meeting those needs. If the client/resident is accepted for placement the staff person responsible for admission shall jointly dev plan with the client/resident and/or client's/resident's authorized representative referral agency/person, physician, social w consultant. Additionally, the law requires that the referral agency/person inform the licensee of any dangerous tendencies of the cl

NOTE: *For Residential Care Facilities for the Elderly, this form is not required at the time of admission but must be completed if it is determi needs have not been met.*

BACKGROUND INFORMATION: *Brief description of client's/resident's medical history/ emotional, behavioral, and physical problems; functiona mental; functional capabilities; ability to handle personal cash resources and perform simple homemaking tas likes and dislikes.*

NEEDS	OBJECTIVE/PLAN	TIME FRAME	PERSON(S) RESPONSIBLE FOR IMPLEMENTATION
SOCIALIZATION — Difficulty in adjusting socially and unable to maintain reasonable personal relationships			
EMOTIONAL — Difficulty in adjusting emotionally			

(Continued on Reverse)

NEEDS	OBJECTIVE/PLAN	TIME FRAME	PERSON(S) RESPONSIBLE FOR IMPLEMENTATION
MENTAL — Difficulty with intellectual functioning including inability to make decisions regarding daily living.			
PHYSICAL/HEALTH — Difficulties with physical development and poor health habits regarding body functions.			
FUNCTIONING SKILLS — Difficulty in developing and/or using independent functioning skills.			

We believe this person is compatible with the facility program and with other clients/residents in the facility, and that I/we can provide the care as specified in the above

TO THE BEST OF MY KNOWLEDGE THIS CLIENT/RESIDENT DOES NOT NEED SKILLED NURSING CARE.

LICENSEE(S) SIGNATURE

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I have reviewed and agree with the above assessment and believe the licensee(s) other person(s)/agency can provide the needed services for this c

CLIENT'S/RESIDENT'S AUTHORIZED REPRESENTATIVE(S)/FACILITY SOCIAL WORKER/PHYSICIAN/OTHER APPROPRIATE CONSULTANT SIGNATURE

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I/We have participated in and agree to release this assessment to the licensee(s) with the condition that it will be held confidential.

CLIENT'S/RESIDENT'S OR CLIENT'S/RESIDENT'S AUTHORIZED REPRESENTATIVE(S) SIGNATURE

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